Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: DR. AHMED KHALIFA 1415 S. HWY 6, SUITE 400D SUGARLAND, TX 77478	MFDR Tracking #:	M4-09-B519-01
Respondent Name and Box #: **05** TRAVELERS INDEMNITY CO OF CONN		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: The original dispute packet does not contain a position summary from the Requestor

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $1152.15
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The Provider's Request for Medical Dispute Resolution involves a dispute over reimbursement for destruction of leg neuromas by neurolytic agent with associated procedures. The Claimant suffered an amputation of the lower left leg at mid calf. The Provider submitted medical billing with ICD-9 diagnosis code 897.0, unilateral traumatic amputation of the leg below the knee. The Carrier reviewed the billing and denied reimbursement for the services as the services billed did not match the diagnosis code or the medical documentation submitted with the billing. The Provider's operative report documents neurolytic destruction of neuromas above and below the knee on the left leg. The CPT codes which the Provider billed, however, are all for lumbar spine procedures. The primary and secondary CPT codes which the Provider billed, however, are all for lumbar spine procedures. The primary and secondary CPT codes, 64622 and 64623, are for "Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral". This indicates these CPT codes are for neurolytic destruction at the lumbar and sacral spine levels. This is not the procedure documented in the operative report, as that report documents neurolytic destruction above and below the knee in the left lower extremity. The subsequent CPT codes billed are also lumbar spine treatments. CPT code 77003 is fluoroscopic guidance of a needle for injections for "spine or paraspinous diagnostics". CPT code 72100 is "radiologic examination, spine, lumbosacral". Although the operative report documents x-rays were taken of the left leg, no x-rays of the lumbar spine are documented. The correct CPT code for lower extremity radiological examinations is CPT code 7655 {sic} or 76590, depending on the portion of the leg. Finally, CPT code 95937, neuromuscular testing, did not match with the other procedures being billed. As all billing was lumbar neurolytic procedures, neuromuscular testing was inconsistent with the other procedures billed. The Carrier contends this billing was reviewed consistent with Medicare coding requirements, as documented by the W1 ANSI code denial documenting "payment based on Medicare payment policy", and reimbursement was properly denied."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
3/17/09	64622, 95937 x2, 77003-26 x2, 72100-26 - N/A	1 thru 11	$0.00
4/14/09	64622, 64623, 95937 x2, 77003-26 x2, 72100-26 -N/A		$0.00
Total:			$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011 (a-d), titled *Reimbursement Policies and Guidelines*, and 28 TAC Section 134.203, titled *Medical Fee Guideline for Professional Services*. The Guideline shall be effective for professional medical services provided on or after March 1, 2008.

1. These services were denied by the Respondent with reason code "17- Payment adjusted because requested information was not provided or was insuff/incompl. Review of submitted documentation does not substantiate billed serviced." and " W1- Workers Compensation state F/S adj. Payment denied based on Medicare payment policy."
2. Review of the information submitted in this dispute indicates there is only the original explanation of benefit (EOB) submitted for the above date of service. There is no reconsideration EOB submitted.
3. Rule 133.307(c)(2)(B) states in part: Requests for medical dispute resolution (MDR), the provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB. The Requestor's dispute indicates that a reconsideration was faxed to the carrier but does not include a confirmation or receipt that the Carrier actually received the reconsideration request.
4. The Provider submitted billing with Current Procedural Terminology (CPT) codes 64622, 95937 x2, 77003-26 x2 and 72100-26 for date of service 3/17/09. The Provider also billed CPT codes 64622, 64623, 95937 x2, 77003-26 x2 and 72100-26 for date of service 4/14/09.
5. The descriptions of the CPT codes by the American Medical Association (AMA) are as follows:
   64622 – Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level
   64623 – (add on code) lumbar or sacral, each additional level (List separately in addition to code for primary procedure.
   95937 – Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method.
   77003 –26 - Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction.
   72100-26- Radiologic examination, spine, lumbrosacral; 2 or 3 views.
   – Modifier 26 indicates professional component.
6. The documentation the Requestor submitted in this dispute to support the dates of service is reviewed. For the date of service 3/17/09 the Provider documented under "Procedures Performed" 1. Radio-frequency ablation with destruction of neuromas in <u>below knee stump of the left lower extremity,</u> and listed CPT 64622 and 64623 (x3). 2. Neuromuscular junction testing with electrical stimulation and listed CPT 95937 (x3) <u>Three</u> neuromas. 3. Fluorscopic guidance and listed CPT 77003 (x3) <u>Three</u> neuromas. 4. Radiological examination of the <u>left BKA</u> with x-ray hard copy, and listed CPT 72100-26. Results: No gross signs of infection of the residual stump noted, except as otherwise stated. The Provider documented under "Procedure in Detail" that the services were performed on the left stump. The documentation does not reflect any procedures performed on the spine as the Provider billed nor were any spine x-rays taken. It is unclear to the Division why the Provider is billing for services related to the spine when the services were actually performed on the lower extremity.
7. The documentation submitted for date of service 4/14/09 is identical word for word to the documentation for 3/17/09 with the only exception being the date is changed and that the 3/17/09 under preoperative diagnosis the provider lists left below knee amputation neuromas and for 4/14/09 the Provider documents the services were for left above knee amputation. Also noted is that the documentation is not signed as required by Medicare.

8. Both of the bills the Provider submitted for reimbursement do not have supporting documentation for the services billed.
9. The Requestor contact, Dr. David Rabbani submitted a letter to the Division responding to the Carrier position summary with cc: to the Carrier. The letter submitted states in part, “These procedures were pre-authorized.” No pre-authorization is submitted in this dispute to support this statement.
10. 28 TAC Section 134.203(a)(5) states: "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
11. Therefore, for the reasons noted above, reimbursement to the Requestor is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1
Texas Government Code, Chapter 2001, Subchapter G
134.203, 133.307 and 133.210

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Auditor Medical Fee Dispute Resolution	11/5/09 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.